CRIMINAL JUSTICE RESPONSES TO OFFENDERS WITH MENTAL ILLNESS

HEARING

BEFORE THE

SUBCOMMITTEE ON CRIME, TERRORISM, AND HOMELAND SECURITY

OF THE

COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

MARCH 27, 2007

Serial No. 110–32

Printed for the use of the Committee on the Judiciary

Available via the World Wide Web: http://judiciary.house.gov

U.S. GOVERNMENT PRINTING OFFICE

34–359 PDF WASHINGTON : 2007

For sale by the Superintendent of Documents, U.S. Government Printing Office
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CRIMINAL JUSTICE RESPONSES TO OFFENDERS WITH MENTAL ILLNESS

TUESDAY, MARCH 27, 2007

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON CRIME, TERRORISM,
AND HOMELAND SECURITY
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Subcommittee met, pursuant to notice, at 1:06 p.m., in Room 2141, Rayburn House Office Building, the Honorable Robert Scott (Chairman of the Subcommittee) presiding.

Present: Representatives Scott, Conyers, Johnson, Jackson Lee, Davis, Forbes, Sensenbrenner, Coble, and Chabot.

Staff present: Veronica Eligan, Professional Staff Member; Ameer Gopalani, Majority Counsel; Bobby Vassar, Majority Chief Counsel; and Michael Volkov, Minority Counsel.

Mr. SCOTT. The Subcommittee will now come to order.

And I am pleased to welcome you to today's hearing before the Subcommittee on Crime, Terrorism, and Homeland Security, on criminal justice responses to offenders with mental illness.

We are at a crossroads with regard to treatment of people with mental disorders who are brought in to the criminal justice system. People with mental illnesses are overrepresented compared to their percentage in the general population in all parts of the criminal justice system; in their contact with law enforcement and the courts and jails and in prison.

A recent Department of Justice study found that while approximately 5 percent of the U.S. population has a serious mental illness, 16 percent of the prison or jail population has such illnesses. This large proportion of mentally ill persons in our jails and prisons is part of a growing trend to transfer individuals who used to be tracked for mental health treatment straight to jail.

One problem contributing to this trend is the lack of programs which train law enforcement to identify and properly handle offenders with mental illness. Mentally ill offenders create enormous problems for both arresting officers and holding facilities, even for temporary periods. Traditional law enforcement strategies can confuse and threaten people with mental illnesses, which can lead to behavior that sometimes results in severe injury to these individuals and to the officers.

This is why many communities have created crisis intervention teams, one form of collaboration between law enforcement and the mental health system. There are somewhere between 150 to 200

law enforcement agencies in this country with crisis intervention teams.

These teams have proven to work. Through them, officers not only spend less time admitting individuals with mental illness as compared to arresting them, but there is also a decreased number of injuries resulting from and to police.

Another problem contributing to the high incidence of offenders with mental illness in jail is simply the lack of mental health treatment, particularly for non-violent offenders. Once incarcerated, people with mental illness have difficulty obtaining adequate treatment. They are at high risk of suicide, and they may be preyed upon by other inmates.

Unfortunately, reports in the media tend to focus on sensational, violent crimes committed by people with mental illness. Even though there are offenders with mental illness who commit serious crimes for which arrest, adjudication and incarceration are entirely appropriate, the majority of those with mental illnesses are those who are incarcerated at low-level, non-violent offenses and they require a more comprehensive approach than simple incarceration.

And one approach to this problem that we will be exploring in this hearing is the establishment of mental health courts. They are modeled after drug courts, and mental health courts divert select defendants with mental illnesses into judicially supervised community-based treatment.

All mental health courts are voluntary. In the 1990's, only a few court-based programs identifying themselves as mental health courts were accepting cases. By 2006, 113 mental health courts were operational.

These courts have demonstrated success. For example, a study of defendants of the mental health court in Broward County, Florida, found that they were twice as likely to receive services for their mental illnesses, they were no more likely to commit new crimes, and they spent 75 percent fewer days in jail compared to defendants with similar mental illnesses and criminal charges who did not participate in the mental health court.

Finally, in this hearing, we hope to explore the need for additional funding under the Mentally Ill Offender Treatment Crime Reduction Act. This act provides funding for a wide range of programs, including mental health courts and crisis intervention teams. Five million dollars was appropriated for fiscal year 2006 and 2007, well short of the $50 million authorized by the act. This hearing will hopefully bring to light how inadequate this current funding level is.

Repeated arrests and incarceration of low-level, non-violent offenders whose mental health needs are not adequately addressed perpetuates a cycle of criminal justice involvement, diverts attention from more serious crimes and does not necessarily respond to the underlying cause of the offense. Having trained law enforcement officials and alternative mental health facilities not only saves injuries, money and frustration for all involved, and even lives, but it also gets an offender the proper treatment and puts them on the path toward productive, fulfilling lives.

And it is my pleasure, at this point, to recognize our esteemed Ranking Member, my colleague from Virginia, Congressman Forbes, for his opening statement.

Mr. FORBES. Thank you, Congressman Scott, and I appreciate your holding this oversight hearing on criminal justice responses to offenders with mental illness.

As always, we appreciate our witnesses being here. And thank you, gentlemen, for taking your time and effort to be here today.

The problem of mentally ill offenders is growing. Unfortunately, mentally ill offenders who are unable to obtain adequate services have been swept up into the wheels of the criminal justice system. This has had a dramatic impact on State and local criminal justice systems, which were not designed to handle the large number of mentally ill offenders.

Approximately 5 percent of the U.S. population has a serious mental illness. Sixteen percent of the prisoner jail population, or over 1 million prisoners, have a serious mental illness. The Los Angeles County jail and the New York Rikers Island jail hold more people with mental illnesses than the largest psychiatric in-patient facilities in the United States.

At the same time, according to a National Institute of Justice survey, 64 percent of jail administrators and 82 percent of probation and parole agency directors indicated the need for improved medical services for offenders with mental illnesses. More than one-fifth of jails have no access to any mental health services at all.

Many criminal justice agencies are unprepared to meet the comprehensive treatment and needs of individuals with mental illness. Poorly trained law enforcement officers can be put in danger when interacting with individuals in crisis and may spend crucial labor hours trying, often unsuccessfully, to connect these individuals to treatment. Jails and prisons require extra staffing and treatment resources for inmates with mental illnesses.

In addition, mentally ill offenders can be affected by incarceration in many different ways from the general population offenders.

There is no question that public safety is critical and that innocent people must be protected from mentally ill offenders. The public safety can be served by a more strategic approach when dealing with mentally ill offenders. And, fortunately, there are effective models for the Subcommittee to examine and support.

The Justice and Mental Health Collaboration Program was created by the Mentally Ill Offender Treatment and Crime Reduction Act of 2004. The act needs to be reauthorized, and I look forward to working with Chairman Scott in reauthorizing this act and adding new and effective tools to the existing act.

The Mental Health Collaboration Program increases public safety by facilitating collaboration among the criminal justice, juvenile justice and mental health treatment and substance abuse systems to increase access to treatment for this unique group of offenders. A mere $5 million, as Chairman Scott mentioned, has been appropriated for the program in 2006 and this current fiscal year.

The importance of collaboration among stakeholders involved in mental health services and criminal justice agencies is critical to improving the treatment of mentally ill offenders.

Such collaboration efforts should include working with the mental health community to provide training, direct assistance and treatment, working with emergency hospitals to which police may take people in crisis, appointing police liaison officers to the mental health community, training police officers on responses to incidents involving offenders with mental illness, initiating assisted outpatient treatment to encourage adherence to prescribed treatment, establishing crisis response sites where police can transport people in mental health crisis as an alternative to hospital emergency rooms or jails and establishing jail-based diversion programs before or after booking to remove detainees with mental illness from jails to treatment settings and establishing mental health courts to make adjudication and sentencing decisions tailored to the needs of each defendant.

Mr. Chairman, I look forward to hearing from today's witnesses, and, once again, thank you for holding this hearing. And I yield back.

Mr. SCOTT. Thank you.

If there are no other opening statements, without objection, we will ask others to introduce their statements for the record.

Our witnesses today, comprise a distinguished panel.

Our first witness will be the Honorable Steven Leifman, who serves as associate administrative judge of the Miami-Dade County Courts Criminal Division, and is currently on special assignment to the Florida Supreme Court as special counsel on criminal justice and mental health. In addition to these posts, he also chairs the Florida Supreme Court Mental Health Subcommittee, as well as the Mental Health Committee for the 11th Judicial Circuit of Florida.

In recognition of his efforts, he has received numerous awards, including the 2003 president's award from the National Alliance for the Mentally Ill and the 2003 distinguished service award from the National Association of Counties.

He received his bachelor's degree from American University and law degree from Florida State University.

Our next witness, Phillip Jay Perry, is a participant in the Bonneville Mental Health Court of the Idaho Supreme Court. The court was established in August of 2002, is located in Idaho Falls, ID, and serves up to 30 individuals who come before the court with felony or serious misdemeanor offenses and who are diagnosed as seriously or persistently mentally ill. He is a graduate of South Fremont High School in Saint Anthony, Idaho.

The next witness will be Sheriff David G. Gutierrez, who was the sheriff of Lubbock County in Texas. He has 30 years of law enforcement experience in the sheriff's office and is currently serving his second full term as county sheriff.

In addition to his current position, he was appointed by Texas Governor Rick Perry as presiding officer of the Texas Commission on Jail Standards. He is on the Board of Mental Health America of Texas, an affiliate of the National Mental Health Association and is a member of the Texas Task Force on Mental Health.

He holds a bachelor's degree in occupational education, specializing in criminal justice and human services, from Wayland Baptist University in Plainview, TX.

Our next witness will be Lieutenant Richard Wall, a police lieutenant with the Los Angeles Police Department. He has served the Los Angeles Police Department since his appointment as a police officer in 1981 and serves as the department's mental illness project coordinator.

He received his bachelor's degree from California State University at Long Beach, a Fulbright fellowship from the National Police Staff College in Bramshill, England and is currently a candidate for a master's degree in history from California State University at Long Beach.

Our final witness will be Mr. Leon Evans, executive director of the Center for Health Care Services in San Antonio, Texas. Prior to holding this position, he served as the director of the Community Services Division of the Texas Department of Mental Health and Mental Retardation in Austin and is chief executive officer of the Dallas County Medical Health Mental Retardation Center in Dallas, Texas, and was executive director of the Tri-County Mental Health and Mental Retardation Services in Conroe, Texas.

He holds both a bachelor's and master's degree in special education from the University of Oklahoma.

Each of our witnesses has already submitted written statements to be made part of the record, and I would ask each witness to summarize your testimony in 5 minutes or less. And to help you stay within the time, there will be little color-coded lights that will start off green, will go to yellow, and when your time is up, they will turn red.

I recognize the gentleman from North Carolina, Mr. Coble, and the Chairman of the full Committee, Mr. Conyers, with us today.

And before we start with our witnesses, we will start with a video, and we will play that at this time.

[Video presentation.]

Mr. SCOTT. Thank you.

Judge? I think we have seen you before.

TESTIMONY OF THE HONORABLE STEVEN LEIFMAN, JUDGE, CRIMINAL DIVISION OF MIAMI-DADE COUNTY COURT, 11TH JUDICIAL DISTRICT, MIAMI, FL

Judge LEIFMAN. I think so.

I want to thank the reporter, Michele Gillen, from CBS in Miami, who really helped expose just a horrible, horrible issue. As you see, it is a pretty sobering thing to watch.

Mr. Chairman and Members of the Subcommittee, we want to thank you very, very much for holding a hearing on this very difficult and critical issue that really for so long has just not see the light of day.

When I became a judge, I had no idea I was becoming the gatekeeper for the largest psychiatric facility in Florida that was our jail.

In 2005, the Miami-Dade County grand jury actually issued a report that was entitled, "The Criminalization of Mental Illness: A Recipe for Disaster, a Prescription for Improvement." After a year of investigation, the grand jury disclosed what most of us have known in the criminal justice system for many, many years: We

have a mental health crisis in our communities, in our States and in this country.

As surgeon general, Dr. David Satcher once called mental illness the "silent epidemic of our times," unless, of course, you are a judge in the criminal justice system, where every single day you see a parade of misery brought on by the consequences of untreated mental illness.

When our country was first founded until the early 1800's, we took people who had serious mental illnesses and put them in jail, because, frankly, we just did not know better. In the late 1800's, a nun was visiting a Massachusetts jail and she came across several men who were literally freezing to death in the jail. They had no charges pending, but they were there because they had mental illness and the community didn't know what else to do with them.

She was so horrified by this scene that she actually began a national movement to take people from jail and send them to hospitals. And by 1900, every State had a psychiatric facility in our country. However, because there was no real treatment, there was no psychiatry, there was no medication, these hospitals grew at a ridiculous rate and they became, frankly, houses of horror.

The normal medication became insulin, electric shock therapy, people were getting hurt, and people were dying. In the 1950's, the first psychotropic medication was developed. That was Thorazine, and, unfortunately, while it has certain positive uses, it is certainly no cure.

In what would have been his last public bill signing, in 1963, President Kennedy signed a $3 billion authorization that would have created a national network of community mental health facilities for the whole country. The idea was that they would take people in these houses of horrors, release them to the communities and make sure they had Thorazine.

Well, unfortunately, and tragically, following the president's assassination and the escalation of the Vietnam war, not one penny of the $3 billion was ever appropriated. However, during that same period of time, a whole slew of Federal lawsuits were filed against the States for operating these horrible facilities.

And in 1972, the first major case reached the Federal court. In what was really, and still remains, a phenomenal opinion, the Federal court issued an opinion with two parts. The first part of the opinion basically orders the deinstitutionalization of the State hospitals. But the second part, which is probably the more important and interesting part, tells the States that if you are going to order the deinstitutionalization, that you shall, you are required to provide community-based treatment for the people you are releasing.

Unfortunately, my State, like the rest of the States, only read the first half of the opinion, and because no money was ever appropriated to President Kennedy's national network of community mental health facilities, there was absolutely nowhere to absorb this population that was now getting released.

The impact has been staggering. In 1955, there were some 560,000 people in State hospitals around the country. Today, there are between 40,000 and 50,000 people in those same hospitals. However, last year, more than 1 million people with serious mental illnesses were arrested, we have between 300,000 and 400,000 in

jail and prisons today and another half a million people with serious mental illnesses on probation. Jails and prisons have become the asylums of the new millennium.

And there are two sad and horrible ironies to this. Number one is, we never deinstitutionalized. What we in fact did is we created the trans-institutionalization. We transferred people from these really horrible hell holes of State facilities to these really horrible jails that you have seen today. And although this is a horrible facility in Miami-Dade, it is nothing unique to most facilities around our country.

The second, and sadder cruel irony, is that 200 years have now passed and jails are once again the primary facilities for people with mental illnesses in this country. It is the one area in civil rights we have actually gone backwards.

As a consequence of this situation, we have seen homelessness increase, we have seen police injuries increase, we have seen police shootings increase, we have wasted tax dollars, and, in effect, we have made mental illness a crime in this country.

In Florida, the police actually initiate more voluntary examinations than the total number of arrests for robbery, burglary and grand theft auto combined. In my own community, we have more than 20 percent of the people in our jail with serious mental illness. We have over 1,000 people on psychotropic medications every day.

We are spending $100,000 daily to warehouse this population. Three of our nine floors of our main jail are now mental health. The conditions are not conducive for treatment. People with mental illnesses stay in jail eight times longer than someone without mental illness for the exact same charge, at a cost of seven times higher.

We have also had 19 people die during an encounter with the police, who have serious mental illness, just since 1999.

And while more and more judges are becoming involved in this issue, the reality is that none of us can fix the problem alone. It is going to take a collaborative effort between members of the judiciary and all the non-traditional stakeholders, such as the public defenders, the State attorneys, our local, State and Federal Government, which is exactly what the Mentally Ill Offender Treatment and Crime Reduction Act sets out to do.

We were very fortunate in my community that we were able to receive a Substance Abuse and Mental Health Administration grant to do something similar.

The results of our collaborative effort have absolutely been astonishing. We have been able to reduce our misdemeanor recidivism rate from over 70 percent to just about 20 percent. We are improving our public safety, we are reducing police injuries, our officers are getting back to patrol in about half the time it took to make an arrest, we are saving our county about $2.5 million annually, it is saving lives and in effect decriminalizing mental illness.

We are hopeful with the legislation that you are looking at we will see similar successes nationally, and we will begin to accomplish what the Federal court set out to do 35 years ago.

Thank you very, very much.

[The prepared statement of Judge Leifman follows:]

PREPARED STATEMENT OF JUDGE STEVE LEIFMAN

Mr. Chairman, Ranking Member Forbes, and Members of the Subcommittee:

Thank you for the opportunity to testify before you today on the topic of "Criminal Justice Responses to Offenders with Mental Illnesses," and the importance of continued funding of the Mentally Ill Offender Treatment and Crime Reduction Act of 2004 (MIOTCRA). My name is Steve Leifman, and I serve as Associate Administrative Judge for the County Court Criminal Division of the Eleventh Judicial Circuit located in Miami-Dade County, Florida.

The Problem:

As a member of the judiciary, I have seen, first hand, the rampant effects of untreated mental illnesses on both our citizens and our communities. A former Surgeon General once called mental illness the silent epidemic of our times; however, for those who work in the criminal justice system nothing could be further from the truth. Everyday our courts, jails, and law enforcement agencies are witness to a parade of misery brought on by untreated mental illnesses. Because of lack of access to community-based care, our police, correctional officers, and courts have increasingly become the lone responders to people in crisis due to mental illnesses. In fact, jails and prisons in the United States now function as the largest psychiatric hospitals in the country.

According to the National Alliance on Mental Illness, roughly 40% of adults who suffer from serious mental illnesses (SMI) will come into contact with the criminal justice system at some point in their lives. Unfortunately, these contacts result in the arrest and incarceration of people with SMI at a rate vastly disproportionate to that of people without mental illnesses.

Often times, when arrests are made it is for relatively minor offenses or nuisance behaviors such as disorderly conduct or simple trespassing. Unfortunately, the result of incarceration tends to be a worsening of illness symptoms due to a lack of appropriate treatment and increased stress. Not only does this contribute to extended periods of incarceration resulting from disciplinary problems and the need to undergo extensive psychiatric competency evaluations, but it makes it all the more difficult for the individual to successfully re-enter the community upon release from custody.

Over time, individuals may become entangled in a cycle of despair between periods of incarceration and jail-based crisis services, followed by periods of disenfranchisement in the community and inevitable psychiatric-decompensation. In addition to placing inappropriate and undue burdens on our public safety and criminal justice systems, this maladaptive cycle contributes to the further marginalization and stigmatization of some of our society's most vulnerable, disadvantaged, and underserved residents.

With a prevalence rate 2 to 3 times greater than the national average, Miami-Dade County has been described as home to the largest percentage of people with serious mental illnesses of any urban community in the United States. It is estimated that at least 210,000 people, or 9.1% of the general population, experience serious mental illnesses; yet fewer than 13% of these individuals receive any care at all in the public mental health system. The reason for this is that Miami-Dade County, like most communities across the United States, lacks adequate crisis, acute and long-term care capacity for people with serious mental illnesses.

On any given day, the Miami-Dade County Jail houses between 800 and 1200 defendants with serious mental illnesses. This represents approximately 20% of the total inmate population, and costs taxpayers millions of dollars annually. In 1985, inmates with mental illnesses occupied two out of three wings on one floor of the Pre-Trial Detention Center. Today, individuals with mental illnesses occupy 3 out of 9 floors at the Pre-Trial Detention Center, as well as beds in 4 other detention facilities across the county. The Miami-Dade County Jail now serves as the largest psychiatric facility in the state of Florida. People with mental illnesses remain incarcerated 8 times longer than people without mental illnesses for the exact same offense, and at a cost 7 times higher. With little treatment available, many individuals cycle through this system for the majority of their adult lives; however, for some the outcome has been far more tragic. Since 1999, 19 people experiencing acute episodes of serious mental illness have died as the result of altercations with law enforcement officers. The most recent event occurred less than two weeks ago.

Unfortunately, the situation in Miami-Dade County is not unique to South Florida, nor is it the result of deliberate indifference on the part of the criminal justice system. Our law enforcement personnel were never intended to be primary mental health providers and our corrections facilities are ill-equipped to function as psychiatric hospitals for the indigent. The fact is we have a mental health crisis in our

communities, in our states, and in this country; and our jails and prisons have become the unfortunate and undeserving "safety nets" for an impoverished system of community mental health care.

In the State of Florida alone, approximately 70,000 people with serious mental illnesses requiring immediate treatment are arrested and booked into jails annually. In 2004 and 2005, the number of examinations under the *Baker Act* (Florida's involuntary mental health civil commitment laws) initiated by law enforcement officers exceeded the total number of arrests for robbery, burglary, and motor vehicle theft combined. Moreover, during these same years, judges and law enforcement officers accounted for slightly more than half of all involuntary examinations initiated. A 2006 report published by the National Association of State Mental Health Program Directors Research Institute found that Florida continues to rank 48th nationally in per capita spending for public mental health treatment. As a result, fewer than 25% of the estimated 610,000 adults in Florida who experience serious mental illnesses receive any care at all in the public mental health system.

The *National GAINS Center* estimates that nationwide over one million people with acute mental illnesses are arrested and booked into jails annually. Roughly 72% of these individuals also meet criteria for co-occurring substance use disorders. On any given day, between 300,000 and 400,000 people with mental illnesses are incarcerated in jails and prisons across the United States and another 500,000 people with mental illnesses are on probation in the community.

The consequences of the lack of an adequately funded, systemic approach to these issues have included increased homelessness, increased police injuries, and increased police shootings of people with mental illnesses. With little treatment available, many individuals cycle through the system for the majority of their adult lives. In addition, the increased number of people with serious mental illnesses involved in the criminal justice system has had significant negative consequences for the administration of the judicial system, as well as public safety, and government spending generally. The cost to Miami-Dade County alone to provide largely custodial care to people with mental illnesses in correctional settings is roughly $100,000 a day, or more than $36 million per year.

Unfortunately, the public mental health system in the United States is often funded and organized in such a way as to ensure that we provide the most expensive services, in the least effective manner, to fewest number of individuals (i.e, those in acute crisis). As a result, the system is arguably set up to fail. In many communities, for example, people who experience serious mental illnesses, but lack resources to access routine care in the community can only receive treatment after they have become profoundly ill and have crossed the unreasonable and catastrophic threshold of "*imminent* risk of harm to self or others." At this point, the individual is typically eligible for crisis stabilization services, but nothing more. Once they are stabilized and no longer present as a "risk of harm," they are often discharged back to the same community where they were unable to receive services to begin with, only to get sick again and require another episode of crisis stabilization services. The result is that instead of investing in prevention and wellness services, public mental health funds are disproportionately allocated to costly crises services and inpatient hospital care.

Historical Perspective:

The current problems and weaknesses of the community mental health system can be traced to historical events that have shaped public policy and attitudes toward people with mental illnesses over the past 200 hundred years. From the time the United States was founded until the early 1800's, people with mental illnesses who could not be cared for by their families were often confined under cruel and inhumane conditions in jails and almshouses. During the 19th century, a movement, known as *moral treatment* emerged which sought to hospitalize rather than incarcerate people with mental illnesses. Unfortunately, this well-intentioned effort failed miserably.

The first public mental health hospital in the United States was opened in Massachusetts in 1833. The institution contained 120 beds, which was considered by experts at the time to be the maximum number of patients that could be effectively treated at the facility. By 1848, the average daily census had grown to approximately 400 patients, and the state was forced to open additional public mental health facilities. A similar pattern was seen across the country as more and more states began to open public psychiatric hospitals. By the mid-1900's, nearly 350 state psychiatric hospitals were in operation in the United States; however overcrowding, inadequate staff, and lack of effective programs resulted in facilities providing little more than custodial care. Physical and mental abuses were common

and the widespread use of physical restraints such as straight-jackets and chains deprived patients of their dignity and freedom.

Around this same time, advances in psychopharmacology lead to the idea that people with mental illnesses could be treated more effectively and humanely in community-based settings. In 1963, legislation was signed which was intended to create a network of community-based mental health providers that would replace failing and costly state hospitals, and integrate people with mental illnesses back into their home communities with comprehensive treatment and services. In what would be his last public bill singing, President Kennedy signed a $3 billion authorization to support this movement from institutional to community-based treatment. Tragically, following President Kennedy's assassination and the escalation of the Vietnam War, not one penny of this authorization was ever appropriated.

As more light was shed on the horrific treatment of people with mental illnesses at state psychiatric hospitals, along with the hope offered by advances in psychotropic medications, a flurry of federal lawsuits were filed which ultimately resulted in the *deinstitutionalization* of public mental health care by the Courts. Unfortunately, there was no organized or adequate network of community mental health centers to receive and absorb these newly displaced individuals. The result is that today there are more than five times as many people with mental illnesses in jails and prisons in the United States than in all state psychiatric hospitals combined.

In 1955, some 560,000 people were confined in state psychiatric hospitals across the United States. Today fewer than 50,000 remain in such facilities. Over this same period of time, the number of psychiatric hospital beds nationwide has decreased by more than 90 percent, while the number of people with mental illnesses incarcerated in our jails and prison has grown by roughly 400 percent. Over the last ten years, we have closed more than twice as many hospitals as we did in the previous twenty and, if this weren't bad enough, some of the hospitals that were closed were actually converted into correctional facilities which now house a disproportionate number of inmates with mental illnesses.

The sad irony is that we did not *deinstitutionalize* mental health care. We allowed for the *trans-institutionalization* of people with mental illnesses from state psychiatric facilities to our correctional institutions, and in the process, made our jails and prisons the asylums of the new millennium. In many cases, the conditions that exist in these correctional settings are far worse than those that existed in state hospitals. The consequences of this system have been increased homelessness, increased police injuries, increased police shootings of people with mental illnesses, critical tax dollars wasted, and the reality that we have made mental illness a crime; or at the very least a significant risk factor for criminal justice system involvement. In 200 years, we have come full circle, and today our jails are once again psychiatric warehouses. To be fair, it's not honest to call them *psychiatric institutions* because we do not provide treatment very well in these settings.

What is clear from this history is that the current short-comings of the community mental health and criminal justice systems did not arise recently, nor did they arise as the result of any one stakeholder's actions or inactions. None of us created these problems alone and none of us will be able to solve these problems alone. As a society, we all must be a part of the solution.

The Solution:

Just as I have been witness to the tragic effects of untreated mental illnesses, I have also had the privilege of observing and working with many dedicated and tireless individuals who are committed to bringing about transformation of the public mental health system and helping to ensure that a diagnosis of a mental illness is no longer a risk factor for arrest, incarceration, or worse.

Across the United States, effective collaborations have been forged, involving diverse arrays of traditional and nontraditional stakeholders, such as providers, consumers, and family members within the mental health care, substance abuse treatment, and social services fields; law enforcement and corrections professionals; representatives from State and local governments and agencies; and members of the judiciary and legal community. These partnerships have established many successful, innovative initiatives serving people with mental illnesses involved in the justice system or at risk of involvement in the justice system, such as mental health courts, pre-trial diversion programs, jail re-entry programs, and specialized crisis response programs for law enforcement officers. In addition, the identification and implementation of promising programs and evidence-based practices such as assertive community treatment, intensive case management, integrated dual-diagnosis treatment, and supportive housing have resulted in more successful and adaptive integration for people with serious mental illnesses in the community.

The Mentally Ill Offender Treatment and Crime Reduction Act of 2004 (MIOTCRA), which authorized the Justice and Mental Health Collaboration Program, administered through the Bureau of Justice Assistance, U.S. Department of Justice, has been crucial to facilitating collaborative community-wide solutions to people with mental illnesses in the criminal justice system. Local communities across the United States that have received funding have been able to design and implement highly successful, collaborative initiatives between criminal justice and mental health systems. This funding has helped to reverse the criminalization of mental illnesses, improve public safety, reduce recidivism to jails and hospitals, minimize wasteful acute care spending, and allowed those with mental illnesses to live a life of recovery in the community. It is imperative that Federal funding of such criminal justice/mental health initiatives be continued.

I'm proud to report that Miami-Dade County has been the recipient of Federal support that has helped place my community at the forefront in the nation in working to de-criminalize mental illnesses and resolve this problem of untreated mental illnesses. Six years ago, the Eleventh Judicial Circuit Criminal Mental Health Project (CMHP) was formed following a two-day summit meeting of traditional and non-traditional stakeholders who gathered to review how the Miami-Dade community dealt with individuals involved in the criminal justice system due to untreated mental illnesses. The stakeholders were comprised of law enforcement agencies, the courts, public defenders, state attorneys, social services providers, mental health professionals, consumers, and families. The outcome of the summit was both informative and alarming. Many participants were surprised to find that a single person with mental illness was accessing the services of almost every agency and professional in the room; not just once, but again and again. Participants began to realize that people with untreated mental illnesses may be among the most expensive population in our society not because of their conditions, but because of the way they are treated.

The result of this summit was the establishment of the CMHP, which was designed and implemented to divert people with serious mental illnesses who commit minor, misdemeanor offenses away from the criminal justice system and into community-based care. The program operates both pre-booking and post-booking jail diversion programs; and brings together the resources and services of healthcare providers, social-service agencies, law enforcement personnel, and the courts.

In 2003, the CMHP in collaboration with the Florida Department of Children and Families received a Federal Targeted Capacity Expansion grant from the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services. With technical assistance provided by The National GAINS Center's *TAPA Center for Jail Diversion,* this funding enabled significant growth within the CMHP which has enabled more effective and efficient response to people with mental illnesses involved in the criminal justice system or at risk of involvement in the criminal justice system.

As a result of the services and training provided by the CMHP, individuals in acute psychiatric distress in Miami-Dade County are more likely to be assisted by law enforcement officers in accessing crisis services in the community without being arrested. Individuals who are arrested and booked into the jail are evaluated, and if appropriate, transferred to a crisis stabilization unit within 24–48 hours. Upon stabilization, legal charges are typically dismissed, and individuals are assisted at discharge with accessing treatment services, housing, and other entitlements in the community.

The CMHP has resulted in substantial gains in the effort to reverse the criminalization of people with mental illnesses, and serves as a testament to the value and potential of true cross-systems collaboration. Key outcomes include reductions in recidivism among misdemeanant offenders in acute psychiatric distress from over 70% prior to program implementation to 22% last year, improved public safety, reduced police injuries, millions in tax dollars saved, and lives saved. To date, more than 1,100 law enforcement officers in the county from 25 of the 32 agencies in operation, have been trained to more effectively identify and respond to mental health emergencies. The idea was not to create new services, but to merge and blend existing services in a way that was more efficient, pragmatic, and continuous across the system. The Project works by eliminating gaps in services, and by forging productive and innovative relationships among all stakeholders who have an interest in the welfare and safety of one of our community's most vulnerable populations.

It is imperative that communities be given the resources to work collaborative to identify and implement promising programs and evidence based practices that will improve the response of the public mental health system and the criminal justice system to people with mental illnesses and/or co-occurring substance use disorders

involved in the criminal justice system or at risk of involvement in the criminal justice system.

The health and well-being of our communities across the United States are inextricably linked to the health and well-being of our residents. To the extent that we continue to allow people with mental illnesses to revolve in cycles of disenfranchisement and despair, our communities will suffer. To the extent that the interventions and services offered are fragmented and do not embrace the concepts of recovery and hope, our communities will suffer. There is a need for a coordinated effort to replicate and expand promising programs and strategies targeting people with mental illnesses involved in the criminal justice system or at risk of involvement in the criminal justice system throughout the United States.

PLEASE SUPPORT CONTINUED FUNDING OF THE MENTALLY ILL OFFENDER TREATMENT AND CRIME REDUCTION ACT OF 2004.

Mr. SCOTT. Thank you. We apologize that we didn't give you the 1-minute notice. I think we have it figured out now.

Judge LEIFMAN. Thank you. Did I make my time? [Laughter.]

Mr. SCOTT. We are going to continue with the—we have a series of votes coming up, so we will hear from one more witness, then we will have to break for a few minutes.

Mr. Perry?

TESTIMONY OF PHILLIP JAY PERRY, COURT PARTICIPANT, BONNEVILLE MENTAL HEALTH COURT, BOISE, ID

Mr. PERRY. I would like to express my appreciation for being invited to speak here today.

I have had urges to hurt people since I was in high school. It wasn't until I dropped out of college and tried to jump off a grain elevator to kill myself did I begin to realize that I had a problem. My parents, who have always been very supportive of me and my illness, coaxed me into going and talking to someone about my problems after that first incident.

That was the first of many times to come that I was institutionalized in a mental health facility. It was there that I found out that everyone doesn't hear voices to tell them to do things like I do. I was diagnosed with a mental illness, and that diagnosis was labeled Schizoaffective Disorder, which essentially means that when not properly medicated, I am delusional with a mood disorder and that disorder being clinical depression.

This was also the first of four times that I have been court committed to the State psychiatric hospital. There, they put me on a lot of medications with side effects that I wasn't too fond of. So when I got out of the hospital, I stopped taking my medications because I found that marijuana helped ease my voices just as good as the medications did, without the side effects that no one would want to live with for the rest of their lives.

There was, however, one bad aspect of the marijuana use: It was illegal, which means I could get in trouble with the law for using it. And that is exactly what I did. I have counted it up and, including the incarcerations in correctional facilities, I have been institutionalized 26 times in my adult life. That would be approximately 14 years.

Since the stays in the correctional facilities were always a result of my drug use, which, in turn, was a factor in trying to help self-medicate my voices, all these institutionalizations were a direct result of my illness.

Every time I have been put in one of the places, they have put me in a drug and alcohol program because I have a drug and alcohol problem. Even in jail they had the AA program, but it seemed no matter how hard I tried, every time I got out I would revert back to my old habits and relapse and end up using again no matter how much sober time I had under my belt.

Fortunately, for me, though, I was introduced to the Mental Health Court Program this last time that I was in jail. This program has changed my life for the best. I feel I can live a sober and relatively mentally stable life because of the tools and skills that the program has taught me. I do feel the program is a great program in itself.

I can't speak for any of the other mental health programs around the United States, but they wouldn't be as good as ours is if it weren't for the people like Judge Moss, Eric Olson and Randy Rodriquez. What I am trying to say is that it wouldn't be as successful if it weren't for the people who run it like the ones I mentioned, who are caring, compassionate people.

[The prepared statement of Mr. Perry follows:]

PREPARED STATEMENT OF PHILLIP JAY PERRY

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Mr. SCOTT. Well, thank you very much. Thank you.

And, Sheriff, we will be back in about—I think we have one 15-minute—we have four votes, so it will probably be close to half an hour.

[Recess.]

Mr. SCOTT. The Committee will come to order, and I appreciate your patience.

Sheriff Gutierrez?

TESTIMONY OF SHERIFF DAVID G. GUTIERREZ, LUBBOCK COUNTY SHERIFF'S OFFICE, LUBBOCK, TX

Sheriff GUTIERREZ. Mr. Chairman, Vice Chairman, distinguished Members of the Subcommittee, my name is David Gutierrez, sheriff of Lubbock County. I appreciate the opportunity to speak on the mental health issues in the criminal justice system.

As sheriff, I deal with the frontline issues; as Texas sheriff, with 254 counties in the State of Texas. In my lengthy law enforcement experience, I have recognized and understood the initial impact on the frontline system. As sheriff and the keeper of the jail, we also, I also understand, as well as many sheriffs across the country, the enormous responsibility, the costly responsibility of maintaining the mental health issues in detention facilities.

In Lubbock County, law enforcement on the front end, the peace officer is trained to take care of the situation, the problem. What we have found is, as sheriff, looking at the facility and the number of assaults, arrests, the number of suicide attempts and actual suicides in a detention facility concern me greatly.

We pulled in our local mental health provider to look at a memorandum of understanding when I became sheriff, and what we did at that time was coordinate from the front end level with the local mental health providers to form a memorandum of understanding and we dealt with to provide on-call, on-site assistance by their crisis intervention counselors to come to the scene when a law enforcement officer is dealing with a situation which he may believe may be the result of unusual behavior.

Number two is, if the individual is arrested and brought into the county jail, that that crisis team, once it is recognized by the detention officer, that the crisis team is called and arrive within 4 hours at the county jail to assist us in the continuum of care, to help us evaluate that individual. We also treat all individuals as indigents so that care services can be provided for them.

Now, while this MOU was just the beginning step locally, it is not the end. As sheriff and chairman of the Texas Commission on Jail Standards, we are looking at the whole State of Texas. The legislature has directed the Texas Commission on Jail Standards to look at the frontline issues across the State when it comes to mental health issues.

Early in the introduction, you have stated all the true concerns that we are facing as law enforcement officers across the country, and as a result of that, we are looking statewide at the front end.

And the legislature directed the Texas Commission on Jail Standards to look at the issues. What we have found is that in the institutional division, the prison system in Texas, there is a chart here that out of 151,000 individuals incarcerated in the State of Texas, 45,000 were actually in fact consumers of the mental health

system. They were actually patients at one time of the State mental health system—45,000, 30 percent. This was the result of a 2005 report that the legislature performed on the prison system. The Texas county State system, the county system, there are over 70,000 individuals.

When looking at the 45,000, those individuals come in from the frontline, on the street, from local cities and counties and sent to the State institution. What we need to identify, and what we are identifying this time, as the chairman of the Subcommittee that oversaw the 254 counties and the recommendations to the legislature, is that we oversee the county jails and develop a medical assessment, suicidal mental health evaluation at the intake, when an individual is arrested, also to cross-reference the statewide care system, which is a statewide database for all individuals who have received treatment in the State mental health system, to identify cross-reference with that database to determine if in fact they are mental health consumers when they arrive into the beginning of the criminal justice system. So in that place, we may possibly divert these individuals.

We are also requiring every county jail to have a diversion plan and a memorandum of understanding with their local mental health provider. That means to get them to communicate, to talk, to assist them in the continuum of care and medical protocol for their medical issue so that we can continue that care throughout the criminal justice system and possibly divert them from the criminal justice system.

My concern is, when individual justice must be done, individuals that violate the law must be incarcerated. The problem is, did the individual intentionally and knowingly violate the law or was it a result of a mental health disability? If that in fact is the case, we must deal with the mental health issue prior to dealing with the violation of the law.

I want to thank you for allowing me to be here today, and thank you for your commitment to this issue. There are millions of individuals, particularly families, who have been impacted by the lack of appropriate care in facilities for the men and women with mental health impairments.

Too often an individual with mental health impairments become the responsibility of the criminal justice system, because it is easier and safer to have them behind bars rather than in society. And with your help today, we can work together to create some State and national guidelines to divert these individuals and to assist them with proper care.

Thank you.

[The prepared statement of Sheriff Gutierrez follows:]

PREPARED STATEMENT OF DAVID G. GUTIERREZ

Mr. Chairman, Vice-Chair, and distinguished Members, my name is David Gutierrez, Sheriff of Lubbock County, Texas. I want to thank you for the opportunity to speak to you about some serious issues we are facing in the criminal justice system today. As a Sheriff and a 30-year veteran of law enforcement, I have seen our criminal justice system evolve and have faced the tremendous challenges in the growth of not only our law enforcement on the front line—the first responders—but in the growth of our detention and institutional systems.

In Texas, as in many states, the Sheriff is the keeper of the jail. While we continue to provide law enforcement services and maintain peace in the county, the

Sheriff receives all individuals arrested by every peace officer, including city police officers, county deputies, state police, and federal agencies. Law enforcement officers are trained to maintain the peace and arrest individuals when laws are violated. During initial contact by law enforcement officers, many individuals interviewed may be disoriented and become combative and result in additional charges, such as Aggravated Assault on a Peace Officer or Attempted Capital Murder on a Peace Officer, being added to further compound the original breach of the peace. These charges, while valid, may be the result of a mental health or special needs issue. Most peace officers across the country are not trained on recognizing these symptoms.

Once arrested, the individual is transported to the local county jail, where they are processed and the uncooperative individual is then treated accordingly. Additional charges may be added there if a detention officer is assaulted.

The reality is that the jails and prisons of criminal justice systems nationwide have become the institutions at which individuals with mental impairments/special needs are placed. There are no standardized methods used to identify them prior to or during the incarceration process. When mentally impaired offenders arrive at correctional facilities the jail staff, in most cases, does not have the professional training or understanding to address their needs or the circumstances surrounding their incarceration. As a result, attempted and achieved suicides, inmate-to-inmate assaults and inmate-to-officer assaults have dramatically increased in our jail and prison facilities.

In 1998, in Lubbock County, Texas, a "Memorandum of Understanding" (MOU), was developed with the Regional Mental Health and Mental Retardation unit to:

- Provide on-call Crisis Intervention Counselors to come to the scene when law enforcement officers believe the suspect being detained may have a mental disorder to indicate a need for diversion prior to arrest.
- Utilize an on-site mental health assessment at the correctional facility to determine if a suspect has a possible mental health issue, and if that assessment indicates a mental health issue, diversion to a local mental health facility could be an option in lieu of incarceration.
- If jail officials, during the booking process, have reason to believe an individual may have a mental health issue, the Crisis Intervention team will arrive within 4 hours at the jail facility and interview the individual for mental health services
- All individuals arrested are treated as indigents while incarcerated and receive treatment and medication for continuum of care.

The MOU in Lubbock was a major step in assisting individuals entering the criminal justice system with mental health/special needs issues; this was just the beginning of a front line attempt to an enormous problem. One of the most pressing problems is that even though we have diversion plans in effect there are no diversion facilities statewide to place these individuals. In my opinion, this is one of the crucial areas that we are deficient in.

While we, as Sheriffs', dealt with these issues, the State of Texas was not naïve to these issues. In 1996, the Texas State Legislature statutorily allowed medical information, in accordance with the federal Health Insurance Portability and Accountability Act, to be disseminated between the medical profession and the criminal justice system. This allowed for a continuum of care for individuals which are incarcerated.

In 2006, the Texas Department of Criminal Justice and the Department of State Health Services cross-referenced each other's offender/client databases to establish a prevalence rate of offenders who were former or current clients of the public mental health system. The following is the result of the state's cross referencing:

Texas Department of Criminal Justice
Client Assignment and Registration System (C.A.R.E.) Match Rates
February 2006

	Entire Population	C.A.R.E. Matches
Prison:	151,528	45,628 (30%)
Parolees:	77,167	21,097 (27%)
Probationers:	430,312	57,719 (13%)
Totals:	*659,007*	*124,444 (19%)*

In addition, a 2005 report prepared by the Texas Commission on Jail Standards, found that 29% of inmates sentenced to prison had been identified as being a former mental health client, but had not been identified as an individual with mental health issues while at the county jail when processed.

Following those findings, a committee directed by the Texas Legislature was formed to determine what can be done to appropriately handle the prevalence of offenders with mental health impairments and the lapses in identification, along with other issues. The committee recommended the following:

- All 254 Counties and their respective Sheriffs' Offices in Texas develop and have a MOU and Diversion Plan for individuals with mental impairments with the 41 Regional Mental Health and Mental Retardation units;
- That the Texas Commission on Jail Standards oversee as part of annual jail inspections:
  - A medical screening form is part of the initial intake;
  - A cross reference with the state's C.A.R.E. system is performed on all individuals arrested to determine if an individual is a client of the public mental health system. This will assist law enforcement, jail officials, the public defender and the county/district attorney's offices in the adjudication of their cases.
- That the C.A.R.E. system be made available by computer to be accessed by any Texas law enforcement officers. This information should be available immediately while the officer is making contact with the individual/suspect to help determine an appropriate course of action by the officer for possible diversion and;
- That all 80,000 Texas Peace officers have Crisis Intervention Training as part of their 40 hours of state-mandated continuing education. This would assist with early-assessment during the initial contact with an offender and possible diversion to the criminal justice system.

The impact to the families of mentally impaired offenders can be, and too frequently is, catastrophic. Many families with a mentally impaired family member turn to the law enforcement community as a last result, no longer being able to deal with the individual's violent tendencies. This cry for help usually comes at a point of calamity with their mentally impaired family member. Due to their extreme or erratic behavior, many offenders with mental impairments are injured or killed while in contact with law enforcement during this time of crisis. Law enforcement and detention administrators across the United States are greatly concerned that they do not have the proper tools, training, and information at their disposal to ensure that offenders with mental impairments are dealt with in a safe and suitable manner, which would provide positive outcomes for everyone involved in these situations.

The bottom line is that we need to hold those who intentionally violate the law accountable, and help those whose condition makes them incapable of intentionally violating the law.

In conclusion, I want to thank you for your commitment to this issue. There are millions of families impacted by the lack of appropriate facilities for men and women with mental health impairments. Too often an individual with mental health impairments becomes the responsibility of the criminal justice system because it is easier and safer to have them behind bars rather than in society. With your help we can work together to create state and national guidelines that will divert these individuals to more appropriate facilities.

Mr. SCOTT. Thank you.

Mr. Wall?

LIEUTENANT RICHARD WALL, LOS ANGELES POLICE DEPARTMENT, LOS ANGELES, CA

Mr. WALL. Thank you, Mr. Chairman.

Distinguished Members, a man I will call Mike lives in south Los Angeles. He is a 31-year-old African-American male with his first documented contact with the Los Angeles Police Department was January 21, 1993, when, at the age of 17, he attempted to take his life to stop the voices in his head.

Over the next 12 years, he was placed on a number of mental health holds, as his delusions became more severe, his actions more desperate. During the 17-month period between July of 2004 and November of 2005, Mike was repeatedly refusing to take his medications and fell into a pattern. On the 15th, 16th, 17th of every month, he would begin acting out; on the 18th, 19th and 20th, he would become violent; on the 21st, 22nd and 23rd, he would attempt suicide by cop.

During this 17-month period, his actions generated 48 calls for police services, resulting in 22 mental health holds. On the three occasions he attempted suicide by cop, I asked him, I talked to him about it, I said, "Why did you want to kill yourself? Why did you want the police to kill you?" And his response is very simple: "To stop the voices in my head."

While Mike's story is remarkable, unfortunately it is repeated in cities and towns across this Nation on an hourly basis, if not more frequently.

Laws identifying who can place a patient on a mental health hold vary, but one option is available to everyone. At 3 a.m., when there is a mental health crisis call, there is one agency that will respond, and that is law enforcement. You dial 911 and you will get police officers who will use the best training that they have to get this patient to the appropriate mental health facility.

An interesting thing to note, in 2004, I conducted a review of Los Angeles Police Department calls for service involving the mentally ill. Ninety-two percent of those calls came from family members and caregivers. This is contrary to the stereotype of the almost mentally ill person who assaults somebody walking down the street. While that does happen on occasion, it is more frequently that the victim of the assault is a family member and then the police are called to respond.

There are three basic models to respond for law enforcement: One is the CIT Program, which we have talked about; the second is a co-response model, which partners the Department of Mental

Health clinician or specialist with a police officer, and the last is one that is handled by most county departments of mental health.

In Los Angeles, we have a combination where we have all three. We have CIT, we have a co-response model, and we have a very active county department of mental health who has its psychiatric mobile response teams, or PMRTs.

We respond to a number of crisis calls. They include suicide in progresses, barricaded suspect scenarios, and I will point out that on barricaded suspect scenarios in Los Angeles, 37 percent of those calls, over one-third, resulted in no criminal charges being filed. The subject was placed on a mental health hold.

We also respond, unfortunately, to a number of calls within the Los Angeles County school district, within the Los Angeles Unified School District, in which case twice a week our teams are responding to crisis calls involving children under the age of 10 who are actively attempting suicide. Think about that for a second: Children under the age of 10, twice a week, in Los Angeles, are attempting suicide, and we are responding to those calls.

This is clearly an issue that has been forced on law enforcement, and, in essence, law enforcement has become the de facto mental health triage system for the Nation.

The important thing here is to remember that our goal is to provide training for these officers. The goal of training is to reduce violent encounters of the mentally ill, that is it. And we need your support through the Bureau of Justice grants and other funding to help fund this type of training.

Again, we have a very unique situation within the city and county of Los Angeles, within the city, specifically. We have a program that is unrivaled anywhere, and it is truly as a result of the leadership at the top. This can't be done without the buy-in at the top of the ladder.

Dr. Marvin Southard, the director of the Department of Mental Health for the County of Los Angeles, and Chief William Bratton, the chief of police of Los Angeles, have committed to expand these programs and work on these programs.

In 2003, we had 13 officers assigned to my unit. Today, we have about 45 officers and 25 clinicians, for a total of 70 people, and our next budget for next fiscal year has even more of an increase. The old saying that actions speak louder than words, well, I have to say that the actions of Chief Bratton and Dr. Southard are truly deafening.

Our motto in my office is very simple, and I truly believe in this, our motto is, "Every day you go to work you save a life." And I truly believe that. We have encountered people in severe crisis who are at high risk for suicide, high risk for death at the hands of another, high risk for suicide by cop.

And every time we respond to a call, it is not the sexy stuff of running into the burning building and rescuing the children, but every time we encounter a 90-year-old woman who can't meet the basic needs for food, shelter and clothing as a result of her mental illness, she will die in that situation if it wasn't for the officers' actions that we take every day.

And, again, we appreciate your continued support in this area. Thank you.

[The prepared statement of Mr. Wall follows:]

PREPARED STATEMENT OF RICHARD WALL

Overview

A man I will call "Mike" lives in South Los Angeles. He is a 31 year old, African American male, who suffers from mental illness. He suffers from schizophrenia, depression, and bi-polar disorder. His first documented contact with the Los Angeles Police Department was on January 21, 1993, when at the age of 17, he attempted to commit suicide to stop the voices in his head. Over the next 12 years, he was placed on a number of mental health holds as his delusions became more severe and his actions became more desperate. During the 17-month period between July 2004 to November 2005, "Mike" was repeatedly refusing to take his medications and fell into a pattern of suicidal behavior. The pattern being:

- On the 15, 16, 17th of the month, he would begin acting out;
- On the 18th, 19th, and 20th, he became violent, assaulting either a neighbor or family member; and
- On the 21st, 22nd, and 23rd he would become suicidal.

During this 17-month period, his actions generated 48 calls for police services resulting in 22 mental health holds. On three occasions he attempted to commit Suicide by Cop (SbC) and was the subject of a Barricaded Suspect scenario necessitating a response by the SWAT team and an evacuation of the surrounding neighborhood, displacing approximately 50 residents. On the occasions that he tried SbC, he called the police, advised them that he had a gun and would "kill the police." When the police responded, he would place an object inside his jacket and feign drawing a weapon, hoping to draw police gunfire. When I asked him why he wanted to have the police kill him, he replied, "To stop the voices in my head."

While "Mike's" story is remarkable, unfortunately it is repeated in cities and towns throughout this nation on a daily, if not hourly basis. Clients suffering from serious mental illnesses that either refuse or have no access to treatment, or their treatment is ineffective, generate calls for service for their mental health crises. Laws identifying who can place a client suffering from severe mental illness on a mental health hold vary from state to state; however, one option is consistent throughout the nation. At 3:00 AM, when a client is suffering from a serious episode of mental illness, there is one place that family members and caregivers can call to help. That number is 911. And in every jurisdiction in the nation, law enforcement officers will respond to help get the client to the appropriate mental health facility. In fact, in some jurisdictions, like those in Los Angeles County, a doctor with 30 years experience in a medical emergency room or a paramedic with 20 years of experience cannot, by law, place a suicidal client on a mental health hold. However, a police officer, the day he or she graduates from the police academy can. As a result, the onus of evaluating and obtaining appropriate mental health treatment falls to law enforcement who have become have become the de facto mental health triage service providers.

In 2004, I conducted a review of calls that were identified as involving an episode of mental illness in the City of Los Angeles during the previous year. That review revealed that 92 percent of the calls for service that involved persons suffering from mental illness, the reporting person was either a family member or a caregiver. Contrary to the stereotypical image of the mentally ill being homeless and assaulting innocent passersby, the reality is that many times the victims of assaults by the mentally ill are actually their family members; the ones who care for them on a daily basis with love and understanding. Unfortunately, when these clients begin to act violently, these family members call the police.

There are three basic models for law enforcement responders handling calls for service involving the mentally ill. These are the Crisis Intervention Team (CIT) model where specially trained officers respond to the calls; the co-response models that partner a law enforcement officer and mental health professional; and the mental health model that sends mental health professionals to address the needs of the client after the client has been taken into custody. These models are deployed throughout the nation in many jurisdictions. Of these models, there is no "best" model. Smaller jurisdictions may not have the resources to deploy CIT personnel or field co-response units. Others will use the model that best fits their needs. For example, Memphis, Tennessee has an outstanding CIT program that few can rival; San Diego, California, utilizes co-response Psychiatric Emergency Response Teams (PERT Teams) as this model works best for them.

PROGRAMS IN THE CITY OF LOS ANGELES

In Los Angeles, California, the Los Angeles Police Department has a truly unique program. The Los Angeles Police Department utilizes an approach that involves each of these programs and more. I oversee the Department's Crisis Response Support Section that currently has 45 officers and detectives from the Los Angeles Police Department and 25 doctors, nurses, and clinical social workers assigned to the Los Angeles Department of Mental Health.

The first link in this process is the Mental Evaluation Unit's Triage Desk. These are specially trained officers who handle inquiries from patrol and dispatch personnel to help to identify incidents involving the mentally ill and provide information, direction, and advice to the field personnel. The Mental Evaluation Unit maintains a database of all law enforcement contacts in the City of Los Angeles. This confidential database provides our personnel in the field with information regarding prior law enforcement contacts to assist them in addressing the needs of the client in the field. Those cases that require additional follow-up in the field are referred to our SMART teams.

In partnership with the Los Angeles County Department of Mental Health, Los Angeles Police Department currently has 18 Systemwide Mental Assessment Response Teams (SMART Teams) that provide citywide coverage. These teams respond to mental health crisis calls that include but are not limited to:

- Suicide in progress calls (jumpers, overdoses, etc),
- Barricaded suspect scenarios, hostage situations, and other situations that involve the Crisis Negotiation Team,
- Crisis Response calls such as major disasters (MetroLink Train crash in January 2005) or incidents involving children (e.g. One situation where an individual committed an act of murder/suicide that was witnessed by several of the victim's children), and
- Crisis Response calls to Los Angeles Unified School District involving suicidal children (SMART personnel respond to an average of two calls each week involving suicide attempts by children under the age of ten.).

A recent addition to the SMART teams is the Homeless Outreach/Mental Evaluation (HOME) Teams operating in the "Skid Row" area of downtown Los Angeles. These teams, made up of a police officer and a registered nurse or licensed social worker, work to assist patrol officers who encounter those clients who are also homeless. This program has been extremely successful in providing linkage with mental health services and working to reduce the victimization of the homeless mentally ill.

Additionally, the Los Angeles Police Department holds quarterly CIT training courses and currently has 307 CIT certified officers assigned to field operations. These officers are deployed throughout the City's 19 Geographic Divisions and serve as first responders to mental health crisis calls.

The Los Angeles Department of Mental Health also maintains Psychiatric Mobile Response Teams (PMRT Teams) that are deployed throughout the City of Los Angeles to provide early intervention and assessments prior to the client generating an emergency call. Family members and/or the client's assigned doctor notify these teams of potential problems.

However, one of the most innovative programs in Los Angeles is the Case Assessment and Management Program (CAMP). The goal of the CAMP investigator is to identify those clients who:

- As a result of their mental illness, are at high risk for death by their hands (suicide) or the hands of another (Suicide by Cop); or at high risk to injure another,
- As a result of their mental illness, are the subject of repeated criminal investigations where the nature of the crime is directly related to the client's mental illness, and
- As a result of their mental illness, generate a high number of calls for service that involve emergency services (police, fire, and paramedics).

Cases that are assigned to CAMP are managed by the Los Angeles Department of Mental Health staff and the focus is to get those clients who, as a result of their mental illnesses, commit minor offenses into the mental health system where they can receive appropriate treatment, thus keeping them out of the criminal justice system. To date, CAMP has been extremely effective in this endeavor

The biggest problem facing these programs in Los Angeles County is that there is no effective Mental Health Court or court diversion process. Instead, the CAMP

detectives must work with the prosecutors and public defenders on a case by case basis to achieve, what we believe to be, positive outcomes involving placement and treatment options. This requires our detectives to travel to different courts throughout the County of Los Angeles and spend time educating the respective prosecutors, defense attorneys, and judges on available options. I will let Judge Leifman's testimony address the importance of your support of Mental Health Courts in further detail.

Our CAMP investigators provide regular follow-ups on the subjects of barricaded suspect scenarios. In 2006, 37 percent of all barricaded suspect scenarios resulted in the client being placed on a mental health hold with no criminal charges being filed. These were clients, who were, in most cases, suicidal and armed with weapons, including firearms. In each case, after the client has surrendered, CAMP personnel accompany the client to the hospital and complete the mental health holds. Then, our partners from the Los Angeles Department of Mental Health work with the client and his/her family to obtain treatment and conduct regular follow-ups to ensure that we don't have a repeat occurrence. To date, we have not had any repeat incidents with a client in which CAMP was involved in a subsequent violent incident.

During 2006, our CAMP has successfully placed seven clients on conservatorships; seven clients are in locked psychiatric facilities; two are in State prison, and four homeless mentally ill clients were reunited with their families and linked to services in their home counties. It is important to note that while we work very closely with our partners at Los Angeles Department of Mental Health, we maintain separate databases. Our criminal databases are protected and the information is confidential. Similarly, the databases maintained by Los Angeles Department of Mental Health are also confidential. While limited information can be shared between partners working on a case, that information is kept confidential. For example, as the officer-in-charge, I know the names of some of the clients that we have criminal cases pending on but I don't know their diagnoses.

As I mentioned earlier, police officers and the criminal justice system have become the de facto mental health triage service providers. The largest "treatment facility" west of the Mississippi River is the Twin Towers jail facility maintained by the Los Angeles County Sheriff. That facility has approximately 1,000 beds for mentally ill clients, all of which are full. I won't elaborate on the needs of the county jails in this area as Sheriff Gutierrez is better equipped to address this issue. However, one issue remains constant. That issue is the need for adequate training to provide law enforcement personnel with the best and most appropriate training available.

The goal in training law enforcement in handling calls for service that involve the mentally ill is to reduce violent encounters with this population. That being said, I must add the following caveat: Despite the level of training that law enforcement personnel have, there will always be those situations where the client's mental illness is so severe and their state is so deteriorated, that they will engage officers in violent confrontations. Unfortunately, there will always be those situations where the client's condition is so severe and they have a weapon, that officers will be forced to use deadly force. There is no "magic wand" that can assure that once an officer is trained, they will never have a violent encounter with a mentally ill client.

This is evidenced by the fact that, as I mentioned earlier, the client's family members and caregivers generate over 90 percent of calls for service. In most cases, these are people who know and love the client and have many years of history with him or her. These are people who know the client's moods and behaviors intimately, as in many cases, they have been living with the mental illness for many years. However, many times, the family is forced to call the police because the client has assaulted a family member. Why then, should we place an expectation on an officer that because he/she has taken a 40-hour course on Crisis Intervention Techniques, that he/she will never be forced into a violent confrontation with a client? I would also cite the fact that each year, doctors and nurses who work in our nation's mental health hospitals are violently assaulted by clients with whom they have daily contact and interactions. They recognize that the client's mental illness is the precipitating factor in the aggressive actions and their actions, like those of law enforcement officers, are in response to those actions.

It is clear, however, that by providing training to law enforcement personnel on how to recognize and respond to clients who are suffering from mental illnesses, that violent encounters can be reduced. It is important to identify and fund relevant training in this area. Within the Los Angeles Police Department, we have worked to accomplish this. For example, in the 40-hour CIT course, there is an 8-hour segment on "Psycho-pharmacology." The reality was that most officers, who don't work in the mental health field, could not recall all of the drugs or their use, two weeks after they completed the course. We realized that it was important to provide train-

ing that field personnel can use to identify clients who are experiencing episodes of mental illness and adjust their approach accordingly.

One of the more innovative training modes that the Los Angeles Police Department has developed is the CIT e-learning course. We have taken our 24-hour course and have broken it down into 12 two-hour blocks. As we develop each block of instruction, they are placed on our Department Web. We have found that this delivery system is an effective means to provide this program to all Department employees and is extremely cost effective. Traditionally, when courses are offered, police departments must send officers to a central location for training and, in many cases, backfill their positions in order to ensure that the public safety needs of their respective communities are met.

By utilizing the e-learning modules, field personnel can break the class into digestible segments and take the courses during their regular shifts at their respective stations, while remaining available to respond to emergencies. The effectiveness of this program is truly impressive. 9,100 Department personnel have completed the Los Angeles Police Department's first four-hour block of instruction. A two-hour segment titled, "Introduction to Mental Illness" was completed by 6,727 field and investigative personnel over a four-month period. The next course titled "Mood Disorders" is in the final review and will be released next month.

The goal of the Los Angeles Police Department is to present all 24 hours of e-learning instruction on mental illness to all field personnel, thus raising the basic level of understanding of mental illness to all employees who are likely to encounter clients who are in crisis. Those personnel who wish to become CIT certified can then take an additional 16 hours of interactive instruction and role-playing exercises to improve their expertise. Currently, there are over 400 patrol officers who have expressed an interest in becoming CIT certified.

By all accounts, the programs implemented by the Los Angeles Police Department have been extremely successful. As the program manager, I can truly say that in my 26 years as a Los Angeles Police Department officer, this has been my most rewarding assignment. However, we could not be as effective as we have been without our partners at the Los Angeles Department of Mental Health. As I have looked at programs across the nation, I have noted one particular trend. Law enforcement and the mental health system, whether state, county, or municipal, private or public, have the same objective. That is to get the client into an appropriate setting where he/she can receive the proper help. However, I have also noted that these entities are heading toward the same destination, with the same objectives, but are on separate tracks. As a result, there is a disconnect between these entities, allowing clients to fall through the cracks.

The partnership between Los Angeles Police Department Los Angeles and the Department of Mental Health is truly unique. In our office, a supervisor from the Los Angeles Department of Mental Health occupies the desk across from mine. We are a true partnership and have equal standing in common decisions. Our facility is not in a police station, but an office building in downtown Los Angeles. Our SMART teams drive unmarked police cars with emergency equipment (lights and sirens). Our officers are in plain clothes, which we have found reduces the anxiety of the clients we serve. No where in the nation have I found such a positive relationship between a county and municipal agency.

The reason for the effectiveness of this relationship rests at the top of our organizations. Chief William Bratton and Dr. Marvin Southard have provided absolute support for this program from the beginning. In 2003, we had six SMART teams comprised of 13 Los Angeles Police Department personnel and nine Los Angeles Department of Mental Health personnel. Today, we have 70 total personnel. Both the Los Angeles Police Department and the Los Angeles Department of Mental Health have submitted budgets for the new fiscal year that will increase the unit even more. The old saying that "Actions speak louder than words" holds true. And the actions of Chief Bratton and Dr. Southard are deafening.

You may recall that I opened this testimony with the story of "Mike," the client who was placed on 22 mental health holds in a 17-month period. Well, "Mike" was our first client that was placed in our CAMP Program. In 2006, due to the intensive efforts of our personnel, "Mike" generated one call for service. He has been successfully linked with services and while our CAMP personnel have monthly contact with him and his family. He has not been the subject of a radio call in over a year.

We have a motto in our office. It is a motto that I truly believe in. Our motto is "Every day you save a life." Each time we respond to a call for service, it involves a client that is suicidal, a danger to others, or cannot meet their basic needs for food, shelter, or clothing. Your continued support of these programs is essential. The grants funded by the Bureau of Justice Administration and future funding initiatives are critical to helping us save lives. Thank you.

Mr. SCOTT. Mr. Evans?

TESTIMONY OF LEON EVANS, EXECUTIVE DIRECTOR, JAIL DIVERSION PROGRAM, SAN ANTONIO, TX

Mr. EVANS. Mr. Chairman and all the Members, I am Leon Evans from the Center for Health Care Services in Bexar County, Texas, that is San Antonio. I am also the chairman-elect of the National Association of County Behavior Health Care Directors, an affiliate of the National Association of Counties.

The National Association of Counties has a committee that mirrors your Committee, the Justice and Public Safety Steering Committee, and that committee has passed a resolution asking this body and Attorney General Gonzales to look into the criminalization of the mentally ill by creating some kind of oversight committee.

I have some slides I would like to put up, and the second slide shows our community partnerships, our collaboration. Now, we have had visitors just 2 weeks ago from Canada, the Ministry of Health in Ontario province in Canada, we have had people visit our program from all over the United States. And the thing they marvel at, just like most of the things you have heard today, is the community collaboration, the partnership. They can't get over how the sheriff, the police chief, the judges, everybody involved have come together to work out these problems.

Now, we all know that we are so underfunded, and there is a natural aversion for law enforcement and mental health to work together in the first place. So who is going to make us do it? We need to get community leadership at the Federal, State and local level to come together and develop strategies to overcome these barriers. We need to integrate our Federal, State and local funding because there is not enough.

Now, we have conducted a cost-benefit analysis, we had Dr. Michael Johnsrud, a medical economist at the University of Texas, to do an initial one when we first started. We showed the first year a $3.8 million to $5 million savings in our efforts.

Now, even though we have, like, 46 points where we identified people with severe mental illness who were inappropriately incarcerated into the criminal justice system, we focused on the fact that if you have a mental illness, you shouldn't go to jail in the first place.

So we have a collaboration—if you will go a couple slides—the next slide just kind of shows the entry points. The next slide shows the number of people that are being screened.

Historically, law enforcement officers did not know how to access mental health services. Let me share a story. When we did our first Crisis Intervention Training (CIT), I was visiting with an officer and he was telling how bad he felt when he picked up a person who was delusional. And the example he gave me was he got called to McDonald's because this guy was saying the Lord's prayer and upsetting everybody in the restaurant, and he was saying the Lord's prayer because he was having hallucinations, auditory hallucinations, and he would say the Lord's prayer to drive these voices out of his head.

And the law enforcement officer said, "I didn't know about you guys. I didn't know about the mental health system. I just knew I couldn't leave this guy in McDonald's. I didn't know what to do with him." I said, "Well, what do you usually do with a person like that?" He said, "I take them to the emergency room, if I am close to the ER, or I take them to jail."

And so what we have done is we have a collaboration now where we do minor medical clearance and psychiatric evaluations in a central place. We are diverting people from emergency rooms who used to average 8 to 14 hours in an emergency room waiting for a minor medical clearance or psychiatric evaluation. So you are shackled to a law enforcement office, you are not having a heart attack, you weren't in a car wreck, so you get triaged to the back of the line.

Our Police Chief Albert Ortiz, before we implemented this program, was spending $600,000 a year in overtime pay, plus taking law enforcement officers off the street 8 to 14 hours. Now, with this new crisis center, he can get a medical clearance and psychiatric evaluation in 45 minutes. And he is putting $100,000 of his drug asset and seizure money—that is what most police chiefs buy body armor and weapons with—into this mental health program, because it makes so much sense.

Diversion from our county jail, if you haven't committed a major crime, you are brought to us. Law enforcement officers basically drop them off. We are the mental health authority, we do the disposition. We have all kinds of step-downs. About 20 percent of the people need to be hospitalized.

Other people need observation, short-term crisis services, some people might be urinating in public, sleeping on doorsteps, digging in trash cans or dumpsters. They are brought to us, evaluated by psychiatrists, and not to be found blatantly psychotic or a danger to themselves or others and refusing treatment. So we contract with a shelter. In a lot of these cases, people had been in a shelter before. So we have, kind of, a mental health unit in this public shelter and we try to endear ourselves and get people into treatment.

So that is just one venue that we have.

And I want to make another point real quick, because my time is about out. The Texas Department of Criminal Justice started identifying all these non-violent, mentally ill people in the prison system. So they developed this Texas Correctional Office on Offenders of Medical and Mental Illness Impairments, and they put them on parole and they contract with my organization.

And a condition of their parole is they see the psychiatrist, take their medication, do their alcohol or drug screening, as so ordered, and generally be in compliance with their mental health treatment. Do you know what our revocation rate is? It is less than 3 percent.

And, Sheriff Gutierrez, I think statewide it is less than 5 percent, right?

And that just goes to show you if these people had been treated in the first place, they wouldn't have gotten involved with the criminal justice system. It was their mental illness and those strange behaviors associated with mental illness that brought them in contact with law enforcement.

So I appreciate this Committee's leadership and interest in this. It is a huge subject. It is very costly to society, and it is devastating to the individuals who get jailed because of their mental illness. We don't put people in jail that have heart disease or diabetes, and people with major mental illness shouldn't have to go there either.

Thank you so much. You are very kind.

[The prepared statement of Mr. Evans follows:]

PREPARED STATEMENT OF LEON EVANS

Honorable Chairman and Members of the Subcommittee of the House Judiciary Committee:

My name is Leon Evans, President/Chief Executive Officer of The Center for Health Care Services (Center), a state community mental health center which is the Mental Health Authority for Bexar County/City of San Antonio Texas.

I am Chairman-elect of the National Association of County Behavioral Healthcare and Developmental Disabilities Directors. The organizational mission of this association is to provide county based mental health and substance abuse services across 22 States.

I am also a proud member of the National Council for Community Behavioral Healthcare with a membership of 1,300 mental health centers providing services across our nation.

Additionally, I am a member of the Justice Committee of the National Association of Counties (NACO) that has been active through their membership representing 2,075 member counties and their county judges, commissioners, sheriffs and county jail administrators, in advocating for a new system of response to alleviate the inappropriate incarceration of persons with mental illness and the cost associated with it.

It is an honor to come before this subcommittee on Crime, Terrorism, and Homeland Security of the Committee for the Judiciary of the U.S. House of Representatives regarding "Criminal Justice Responses to Offenders with Mental Illness."

It is an honor to come before you to tell you about our community collaboration in Bexar County. This collaboration created a very successful community initiative known as "The Bexar County Jail Diversion Program." In the last two years, our collaboration has been nationally recognized for its excellence in service, focusing on first line contact within the jail diversion continuum.

In 2006, The American Psychiatric Association recognized the Bexar County Jail Diversion Collaborative with its national "Gold Award" for the development of an innovative system of jail diversion involving community partnerships and collaborations. This award recognized the collaborative innovation of improved services, enhanced access to and continuity of care for persons with mental illness, which resulted in financial savings to the community.

The Bexar County Jail Diversion Program (BCJDP) was also the recipient of the 2006 "Excellence in Service Delivery Award" provided by the National Council for Community Behavioral Healthcare.

The Bexar County Jail Diversion Model has been highlighted in the Substance Abuse and Mental Health Services Administration (SAMHSA) journal for its innovations and creativity. Visitors from all over the United States, including Canada, have come to study this model program in the hope of developing similar models in their communities.

We are in the process of completing our second cost benefit analysis that identifies the costs associated with mentally ill non-violent offenders and the use of public resources such as hospital emergency rooms, jails and prisons. Without proper identification and access to service and treatment, many of these individuals are caught in a never ending revolving door resulting in harm to the individual and the draining of public dollars.

In Fiscal Year 2004, our first economic study reviled that in Bexar County, with the diversion of over 1,700 people an estimated $3.8 million to $5.0 million dollars in avoided costs was actualized within the Bexar County Criminal Justice System.

Economically, it makes sense to divert from incarceration and treat non-violent persons with serious mental illness in different venues and make available crisis services and other treatment modalities outside the criminal justice system. This protects the dignity of persons with a severe mental illness while making sure our county, state and federal dollars are spent in the most effective and efficient way possible. By not providing the appropriate intervention and treatment we are find-

ing that people with mental illness are being incarcerated. This in-appropriate system of incarceration could be considered cruel and unusual punishment.

The Problem:

It is a national tragedy that in today's society, persons with severe mental illnesses, for who the most part are not violent, find themselves caught up in the criminal justice system. Many persons with mental illness are over represented in in-appropriate settings such as emergency rooms, jails and prisons. For sometime, it was thought that about 16% of persons in our jails and prisons had a severe mental illness. More recent studies would suggest that the number could be at least twice as high. This is not only wasteful and inappropriate but delegates' people with an illness to be housed in our jails and prisons rather than treated in the least restrictive most appropriate therapeutic setting.

The reason for this problem is multi faceted. First, in the 60's when psychotropic medicines were being developed and President Kennedy, through the Community Mental Health and Mental Retardation Facilities Act of 1963, initiated the delivery of community based services, states started closing our state hospitals. It was understood that necessary funding would follow these persons back to the community to pay for the treatment and medication. In reality, that did not happen. Today, we find ourselves not only "under-funded," but the funding that has been dedicated to serve persons with mental illness in the community tends to be directed towards outpatient services instead of necessary funding for intensive crisis services. There is little or no services associated with stabilizing persons and re-integrating them into their communities.

Historically, law enforcement and Community Mental Health Authorities have not partnered nor communicated with each other to address these problems! Due to the lack of this poor communication and trust, to date there has been little training, little planning, and therefore poor to limited services. This break-down in communication results in duplicated efforts, inefficiencies and limits the impact of our tax dollars being spent in our communities. It is well known that the average length of stay for these non-violent offenders who end up in our jails is 3 to 4 times longer at 5 to 6 times the cost of their stay as compared to the cost of the stay of a violent offender.

Why is this?

1) These persons lack the resources to advocate for themselves or have the knowledge or ability to access commercial or specialty bonds for release.
2) The nature of mental illness and the lack of public information force a judge to act conservatively in their decision process which extends their stay.

During their stay in the jails, most persons with mental illness usually receive poor treatment for their mental illness. After all, jail and prisons are not therapeutic environments. Many times people that end up in jail do not get referred to mental health services on discharge. Therefore, these individuals end up de-compensating and ultimately end up back in jail and in our state prisons. Inappropriate sentences in state prisons create episode costs that could range in hundreds of thousands of dollars per incarcerations.

We have a failed public policy when it comes to the incarceration of non-violent mentally ill offenders. This does not make sense when it comes to public policy. A non-violent offender taking up space increases overcrowding and reduces bed availability for those individuals who do need confinement.

History has shown us that the current system has caused the suffering, indignity and humiliation for thousands of persons with serious mental illness who have been inappropriately jailed due to the lack of availability of treatment and crisis services within the community. Tax payers, in the end, are paying the price for this failed system.

Our County Judge Nelson Wolff brought together a group of community leaders who formed a collaborative, which has been functioning for several years focused on improved services and driving out waste associated with the criminalization of the mentally ill.

The BCJDP has been designed and developed, through this expansive collaborative effort of community leaders and stakeholders, to ameliorate the practice of utilizing the jail system for the inappropriate "warehousing" of individuals with substantial mental health issues. The thrust of this effort was to also minimize the use of the arrest/booking process of adult offenders with mental illness who by their conduct, are subject to being charged with a minor non-violent criminal offense.

Within four years, from 2003 to date, we have developed a new model of diversion, which focuses on both physical and mental disabilities working closely with law enforcement within forty-six intervention points along a jail diversion continuum. Our

new Crisis Care Center has compressed the waiting time required of law enforcement officers to deliver an individual in crisis for psychiatric assessments and medical screenings. This compression of time has allowed law enforcement officers to be released back into the community within a 15 minute time frame and more appropriately provide service to the community and results in less inappropriate incarcerations and/or inappropriate use of our emergency rooms. It is estimated that in the first year alone, $3.8 to $5 million dollars was saved in the community through our diversion efforts resulting in the reduction of over crowding of the jail and increasing the capacity in our jails for the incarceration of violent offenders. It should also be noted that our emergency rooms are not packed with law enforcement officers waiting for medical clearance and psychiatric evaluations and keeping them from performing the law enforcement functions in the community. This has resulted in avoiding associated overtime costs for those officers who have to wait with the apprehended person needing medical clearance and psychiatric evaluations. We have implemented a number of innovative programs which work closely with the court system, the probation system, and local judiciary at large. We have incorporated probate judges in the development of civil commitment actions which ensure intensive outpatient case management for high utilizers resulting in significant savings as a result of a shortened State hospital stays.

Future:

Engaged efforts are currently in place to reach out to all community stakeholders such that local law enforcement, emergency medical services, hospital districts, the judicial system, local treatment agencies and others gain knowledge of working with persons suffering serious mental illness and the provision of cost effective, least restrictive, clinically effective treatment options within a community collaborative framework.

Conclusion:

We don't put people with diabetes and heart attacks in jails so why do we allow this to happen to our sons and daughters, to our family members who have a serious mental illness. We must treat the illness and not the symptom. We need to improve the quality of life by providing them with more appropriate venues of treatment. The mentally ill do not belong in the emergency rooms and jails for minor criminal offenses committed as a result of their mental illness. The emergency rooms are needed for more serious injuries for those that need the appropriate use of the emergency room. The jails are overcrowded and the mentally ill do not belong there.

Bringing them to an appropriate Crisis Center with an appropriate treatment program can alleviate the crowded situation faced at hospital emergency rooms as well as jails. We need to train law enforcement to become knowledgeable and have an awareness of the need to bring those individuals to us as opposed to jails.

There is a failure in the public mental health system. A Crisis Center, working with judges, and providing services to the mentally ill with additional supports can be a solution to the communities needs. We have many challenges before us but I am pleased to offer an alternative which focuses on community ownership and community collaboration.

Documents for the record include the following attachments:

1. APA Gold Award
2. Jail Diversion Short Presentation
3. National Weekly "Bexar County Story"
4. CCC Dr. Hnatow Article
5. Hollywood CIT Final Version
6. JD Model Lite
7. Written Testimony March 23, 2007
8. SAMHSA Newsletter
9. 3 JOHNSRUD FINAL
10. BCJD Economic Impact Study
11. CCC Brochure
12. Hnatow UHS
13. Jail Diversion White Paper
14. Out of Jail and Into Treatment

Mr. SCOTT. Thank you. Thank you, Mr. Evans.
And I thank all of our witnesses for their testimony.

We will now have questions from the Members under the 5-minute rule, and I recognize myself for the first 5 minutes.

Mr. Evans, you indicated you had a cost-benefit analysis?

Mr. EVANS. Yes, sir. And it is part of your record, and we just contracted in a partnership with the Texas Department of Medicaid. They have a drug vendor program, and drug companies give the State either a reduction in drug costs or, if the drug company's Medicaid division will allow it, can reinvest in the community program.

So part of how we got this done was a partnership with AstraZeneca and the State Medicaid Program. Part of that initiative was to do an extensive cost-benefit analysis. The one that you have copies of just show the cost savings in jail. In reality, there should be savings in the prison system, in the hospital system. If people don't get identified and treated as they come out of jail, and some people will be jailed because of their offense, there will be that revolving door, that recidivism rate. So all these costs are associated with people not getting treated.

And the new cost-benefit analysis done by the Research Triangle in North Carolina should be finished in June or July, and we will have all those associated costs, and also inappropriate hospitalizations.

Mr. SCOTT. Judge—is it "Leifman?"

Judge LEIFMAN. Yes, sir.

Mr. SCOTT. Judge Leifman, are there constitutional standards that we have to achieve to avoid constitutional violations?

Judge LEIFMAN. There are constitutional standards, but I think what has happened is the local jails have become so overcrowded and overwhelmed with the issue they just don't know what to do with the population. We tried to make sure that those constitutional protections are in place, but I think everyone is so overwhelmed with this issue that they are trying desperately to figure out a way to divert people from coming in or once they do come in to divert them out of our systems.

Mr. SCOTT. The situation in the jail in your county, do you think you had crossed the line into a constitutional violation? If somebody filed suit, would we have been in jeopardy?

Judge LEIFMAN. Most likely. But it is ironic because they had been under Federal court orders before. It just doesn't work. And what I think works is when the community comes together to avoid that lawsuit, and you end up spending so much money on a Federal lawsuit to defend it that you waste what you need to do to fix it.

We did a study. We took 31 people who were the highest utilizers in our jail who had serious mental illness. It cost us $540,000 to do nothing, because that is what it costs to keep them in jail when they have mental illness or get them acute care. If you do nothing, you end up spending the money. It is much cheaper and much more efficient to keep them from coming in, and when they do get in to get them out quickly.

Mr. SCOTT. Thank you.

Sheriff, did you have a comment on that?

Sheriff GUTIERREZ. Yes. There are some constitutional issues. I will tell you that, unfortunately, Lubbock County came under a

Federal lawsuit, and during my 30 years of experience our jail was declared unconstitutional by cruel and unusual punishment, and it set the standard for all the jails across Texas for the proper care, medical treatment and assistance.

And the judge is correct, that the problem has become very overwhelming and we are trying to stay on top of those issues, and we are very concerned that we may, once again, return to that Federal guidance or oversight.

Mr. SCOTT. Now, sheriff, you mentioned that 30 percent of the patients were already mental health patients, and I suspect that a lot of others should have been mental health patients. And you treat them all as indigents so there is not a financial barrier to them receiving services once they get to you?

Sheriff GUTIERREZ. Yes. We treat them as indigents so that our local hospital locally can provide the services continuum of care. However, somebody has to pay for it and that is the citizens, the taxpayers, of those counties.

Mr. SCOTT. But since they are treated as indigents and they are in the criminal justice system, the services get provided.

Sheriff GUTIERREZ. We are trying to provide those services. The problem is there is not enough money to be able to fund those issues. That is where we need your assistance to provide that care.

Mr. SCOTT. And if you have a drug court and you want to divert them somewhere, you have to have some services there——

Sheriff GUTIERREZ. To assist them, absolutely. We are looking locally at some mental health courts. The problem is, once again, the funding. We have put together locally——

Mr. SCOTT. And that is not funding for the court, that is funding for the services——

Sheriff GUTIERREZ. Services, absolutely.

Mr. SCOTT [continuing]. That the court will have at its disposal.

Sheriff GUTIERREZ. That is correct.

Mr. SCOTT. Do you want to make a comment, Mr. Evans?

Mr. EVANS. Yes, sir, Mr. Chairman. Most jails do not have this kind of psychiatric and therapeutical talent systems in place. It is not a therapeutic environment, it is a stressful environment, and it is absolutely the wrong place to treat people with mental illness.

Now, if you go to jail because you have created a major offense, you need to be in jail, then you need to be treated, but having our jails and prisons be the substitute for mental health hospitals, that is wrong.

Mr. SCOTT. Thank you.

Mr. Forbes?

Mr. FORBES. Thank you, Mr. Chairman.

Let me once again thank all of you for taking time to come here.

Mr. Perry, thank you for being here and for your testimony.

Lieutenant, can you tell us, what proactive steps can be taken to prevent mentally ill offenders from actually offending?

Mr. WALL. In Los Angeles, we have initiated a new program that focuses exactly on that. It is called our CAMP program, our Case Assessment Management Program. We are the only law enforcement agency in the Nation that maintains a database of law enforcement contacts with the mentally ill, and when these high uti-

lizers come up regularly and we identify people like Mike, the person I was talking about earlier, Mike was our first CAMP patient.

We looked at him, and I said, "We are going to kill him. This person is truly going to die at the hands of law enforcement based on his behavior." As a result, we became very intense in working with the Department of Mental Health.

And I talked with my chief and I said very simply, "Chief, here is the deal: If I can tell you the day a crime is going to occur, where that crime is going to occur and who the suspect is going to be, will you allow me to deploy police resources to prevent that crime?" And the answer is always, "Yes."

Well, if it involves a patient who is suffering from mental illness and we know what his pattern is and we know that on the 15th of the month he is going to begin acting out, why can't we go out on the 13th and talk to his family and see if he has taken his meds, and if he has not, provide linkage with the Department of Mental Health before we have an action or we have an incident?

As a result of that intensive type of procedures with Mike, remember that 17-month period generated 22 holds and 45 calls for service. In 2006, he generated one radio call, and we have not had a radio call in over a year with that individual. Now, we contact him monthly, we still talk to the family every month to make sure everything is being done, but most of that is being driven by the Department of Mental Health because of our partnership with the Department of Mental Health.

Mr. FORBES. Mr. Evans, are there any other effective programs that could be used for collaborative approaches, other than mental health courts, for pre-and post-arrest diversion?

Mr. EVANS. Yes, sir. In fact, we have several. One of the programs is an intensive outpatient commitment, and a lot of people with severe mental illness, also have cognitive learning disabilities, they have a hard time staying compliant with their treatment. They can't remember to take their medications because of their illness. A lot of them don't have significant others or families to help support them.

And so what we have done is we have given, on the civil side, the probate judge a case worker, and we look at people who have had multiple admissions to the State hospitals and they are kind of in and out of compliance of treatment, and we do outpatient commitments, and we do treatment plans around that and report back to her court to see if the person is compliant, similar to what Los Angeles does.

We have had almost a 50 percent reduction in hospital bed-day usage and other public services just by having one case worker there and a judge stand up before this person and say, "I care about your health, you are not being compliant, I am ordering you to see your doctor, take your medication and stay in compliance with your treatment." And it works. It is absolutely amazing, and it is not very costly.

We also have some step-downs for first-time offenders. We have three projects, we have a 60-bed facility for those people who do get put in jail and some mental health step-downs where we actually have treatment and it is overseen by the parole division.

We provide the therapeutic treatment in two 100-bed facilities for substance abusers. Most of these are young people, young family members, a lot of them have kids, and they don't understand what the drugs and alcohol are doing to themselves. And it is a therapeutic environment, and we are starting to show good outcomes there.

So I think there is a variety of other kinds of partnerships with law enforcement and the mental health and substance abuse community that could be provided. I know the National Council of Behavioral Health has 1,300 members in rural frontier and urban settings that stand ready to serve, but there needs to be some way to develop these specialized models, these best practices, these collaborations so we drive out waste and get the best return on our investment with these partnerships.

Mr. FORBES. Thank you.

Judge, thank you for your work on this and the program. Just a quick question, my time is almost out. On your program, does it require the judges participate in the training program as well?

Judge LEIFMAN. We do have some training, and we are now actually looking to install a statewide training program for all the judges in Florida.

Mr. FORBES. Good.

Well, thank you all so much. Sorry I am out of time; I would love to talk with all of you more.

Mr. Chairman, I yield back.

Mr. SCOTT. Thank you.

The gentleman from Georgia, do you have questions?

Mr. JOHNSON. Yes, thank you.

Mr. Wall, prior to the institution of your educational program for the officers, what percentage of the persons who were incarcerated in your jail were suffering from mental illness?

Mr. WALL. I can't give an accurate answer to that for two reasons: Number one, prior to 2004, we didn't keep accurate number of contacts; and, secondly, our patients are not housed—Los Angeles city doesn't have a jail. Ours are housed at the Twin Towers facility with the Los Angeles County sheriffs.

I can tell you from my discussions with the sheriffs, though, that a significant percentage of those patients that are within Twin Towers come from the city of Los Angeles, and, currently, the sheriff maintains approximately 1,000 beds, which at any given time are full.

Mr. JOHNSON. Does anybody else on the panel have any insight?

Judge LEIFMAN. We do. I am with Miami-Dade County. We segregate the people who have mental illnesses in the jails, so we actually had a study done. And we have about 20 percent of the population on psychotropic medication. We are the largest psychiatric warehouse or facility in Florida. We spend $100,000 per day warehousing them in our jail.

Mr. EVANS. In San Antonio, as Sheriff Gutierrez explained, we do a cross-match with the State mental health database, and even though we have this phenomenal diversion program, we still have 16 to 20 percent of folks who go to book-in that have a history of treatment in the mental health system at one time or another. We are also stationed at book-ins so we can divert there also.

And one of the problems is during the crisis intervention training you only can train so many officers at a time, and there are, like, 5,000 law enforcement officers in Bexar County, and at 40 a class, we have only got several classes, so there is still a lot of training to do.

We are starting to train dispatchers and 911 folks, so if somebody is called and its somebody that sounds like they are having mental health problems, one of these specially trained officers show up.

Mr. JOHNSON. Judge Leifman, that is $100,000 per year?

Judge LEIFMAN. Per day.

Mr. JOHNSON. Per day.

Judge LEIFMAN. Thirty-six million dollars a year.

Mr. JOHNSON. Thirty-six million dollars a year. That includes petty criminals as well as——

Judge LEIFMAN. Yes. In fact, what was interesting in the study that we did, about 55 percent of the people that have been arrested were on third degree felony charges, which in Florida is the lowest level of a felony. But 65 percent of them, which was about 1,100 people a year, were on what we would consider an avoidable arrest. It doesn't mean it didn't happen, but it was like battery on a law enforcement officer or resisting with violence. And so it probably occurred, it is just the officer may not have been trained on how to avoid it and the situation escalated as opposed to deescalated.

That is a lot of people that should not have been in our jail to begin with that we could have avoided, put them into a mental health system, which would have been more effective and efficient and cost-effective.

Mr. JOHNSON. Certainly cheaper, because it cost——

Judge LEIFMAN. No doubt.

Mr. JOHNSON [continuing]. You how much per inmate, per day?

Judge LEIFMAN. It is very expensive. I mean, it is a lot less expensive to get them treatment, and it is a lot more humane for them to make sure that they are in a system of wellness and recovery as opposed to one of criminalization.

Mr. JOHNSON. Yet, sometimes, I suppose, when persons—let's take, for instance, Mike. I wouldn't call him a petty crime suspect, but let's suppose that he was a petty crime suspect and he would act out every month according to that schedule that you gave and without proper training officers would come along and lock him up and he wouldn't be able to make bond, and he would languish in the jailhouse for some number of weeks, or perhaps months, until he came to court. And I guess his condition would be stabilized while he was in the jail, perhaps, we would hope.

Judge LEIFMAN. Perhaps.

Mr. JOHNSON. And before he went through this cycle of going to jail, he may have had some Medicaid benefits, he or she. And once he or she was incarcerated, they would cease to be eligible for those Medicaid benefits and unable to pay for the medication that they were not taking.

And so how difficult is it once that type of person gets out to reestablish the coverage so that they can have the medication that at least they can have the option to take?

Judge LEIFMAN. If I may, it is one of the biggest problems we have. It usually takes at least 6 months to get someone their benefit. And when someone is leaving jail they need it the day they are leaving. They need housing, medication and case management the day they leave.

So what we did in Miami-Dade is we are trying a novel approach. We were able to get our county government to give us a lump sum of money on a pilot basis, and what we are doing is signing an agreement with the consumer and Social Security in our county. We are fronting the benefit for them so we are making sure there is housing, medication and case management the day they get out.

When their benefit kicks in, it is retroactive. Instead of it going back to the consumer, it is coming back to us, it replenishes our fund and we are leveraging the Federal dollar, and we will have more money to help the next person.

And so far it's been very, very successful, and it is the only way we can figure out to get around the 6 months, because, quite frankly, we might as well not offer the benefit if you don't give it to them the day they leave, because they are going to go back to substance abuse issues, they are going to get rearrested and they are going to continue to recycle.

Mr. JOHNSON. Yes. Thank you.

Mr. SCOTT. Gentleman from North Carolina, Mr. Coble?

Mr. COBLE. Thank you, Mr. Chairman.

Mr. Chairman, as you know, I think prison overcrowding is one of the most severe problems facing society today, and when you have prison overcrowding involving mentally ill offenders, the problem becomes severely compounded.

I appreciate you all being here.

Judge, does the criminal mental health project coordinate with other jurisdictions interested in focusing on mental illness? And if so, are there distinctions from programs and procedures implemented by other jurisdictions?

Judge LEIFMAN. Yes. We do work with other jurisdictions, and what we have decided is each jurisdiction is a little unique and novel, so we try to work with them to set up a system but to operate it in a fashion that works best for them.

I mean, in Dade County, we have six public crisis stabilization units, so we have a written understanding with them that when someone gets arrested on a low-level misdemeanor offense, within 24 to 48 hours we divert them to one of these crisis units, we try to put a case management system into place and follow them.

Another community may have private hospitals, not a crisis stabilization system, and they will try to work out a similar situation.

Mr. COBLE. I got you. Thank you.

Mr. Perry, at what point did the court take your illness into account when you were having difficulty with the law enforcement people?

Mr. PERRY. The last time I was in jail, my public defender suggested that I try to get accepted to mental health court.

Mr. COBLE. And had you been incarcerated prior to that time——

Mr. PERRY. Yes.

Mr. COBLE [continuing]. Several times?

Mr. PERRY. I have been incarcerated eight times in my adult life.

Mr. COBLE. Mr. Perry, was marijuana the only illegal drug you used that got you into difficulty?

Mr. PERRY. No. I used more than that. Marijuana was the drug that was the one that I was charged for, though.

Mr. COBLE. I got you. Thank you, sir.

Sheriff, how can the Federal Government assess local and State officials dealing with mental health issues, and are certain incentives more effective than others?

Sheriff GUTIERREZ. Sir, I believe that the problem that we are facing is in the continuum of care, and once they are released, it is providing the proper facilities and services for these individuals so that they could possibly not be rearrested. Integration back into the community is paramount, and the lack of resources seems to be the problem that we are facing today.

Mr. COBLE. Thank you, sir.

Lieutenant, how does L.A. review its mental health programs to ensure that they are effective in being well and prudently managed?

Mr. WALL. We have a multilayered approach. One of the first, in fact, is happening tonight in Los Angeles. We have quarterly stakeholders meetings with members of the community where the community can come in and talk on an open forum about issues involving law enforcement and mental illness, their perceptions of what needs to be fixed, and then we actively work on that.

I also report, through my chain of command, semiannually to the Board of Police Commissioners, which in Los Angeles is appointed by the mayor to oversee police operations and set policies and procedures for the department. And so I report to them on a semiannual basis.

And then on top of that, we also are currently under the Federal consent decree. So we are being looked at by the independent monitor and the Federal court, all of which have given our program very high remarks.

Mr. COBLE. I thank you for that.

Mr. Evans, what role do prosecutors and the courts play in your program that you oversee?

Mr. EVANS. We, Congressman, are working with prosecutors in getting peace bonds and mental health bonds for people that get incarcerated, actually get put in jail that have committed a major crime. We also have established a mental health court where we are working with judges on book-in, the original book-in and dockets there for early diversion.

So almost every place in the criminal justice system there is a contact for the mentally ill person. We are working with that branch of government in the judicial system to make sure that justice is served but also that these people get the needed treatment so they don't decompensate and end up getting back involved with law enforcement.

Mr. COBLE. Thank you, sir.

Mr. EVANS. Thank you.

Mr. COBLE. My time is about to expire, Mr. Chairman. I yield back.

Mr. SCOTT. Thank you very much.

And I thank the witnesses for your testimony. This has been very helpful, and, to a large extent, our efforts will be in the Appropriations Committee, but this hearing record will be extremely important. I have talked to at least one appropriator so far who is going to be very supportive of trying to get some additional funding for you.

So thank you very much for your testimony.

And I would ask unanimous consent that a letter from the Justice Center, from the Council of State Governments, be entered into the record. Without objection.

[The information referred to follows:]

JUSTICE CENTER
THE COUNCIL OF STATE GOVERNMENTS
Collaborative Approaches to Public Safety

March 27, 2007

The Honorable Robert C. Scott
Chairman
Subcommittee on Crime, Terrorism, and
Homeland Security
2138 Rayburn House Office Building
Washington, DC 20515

The Honorable Randy Forbes
Ranking Member
Subcommittee on Crime, Terrorism, and
Homeland Security
307 Cannon House Office Building
Washington, DC 20515-4604

Dear Chairman Scott and Ranking Member Forbes:

On behalf of the board of the Council of State Governments (CSG) Justice Center, we applaud your leadership on efforts to improve the criminal justice response to people with mental illnesses and for holding today's hearing. CSG members—state legislators, judges, corrections directors, and other policymakers—confront daily the challenges related to the unprecedented numbers of people with mental illnesses who are cycling through the justice system. They share your concerns that the costs in taxpayer dollars and in the lives of these individuals and their families cannot continue. The need for federal support and involvement could not be more pressing.

Law enforcement officers, who are often the first to encounter people with mental illnesses, spend tremendous resources and time trying to resolve complex incidents in which a person's mental health is a significant factor. And while most of these incidents—many of them repeat calls for service—are usually resolved without use of force, there are significant concerns about the safety of all those involved as well as the need for better outcomes for the person with a mental illness. As the same individuals are arrested again and again, mentally ill offenders become familiar faces in our nation's courtrooms and ultimately fill our jails and prisons. Our corrections facilities are now holding more people with mental illnesses than our inpatient hospitals and the practice is taking its toll on our state budgets, community safety, and the lives of individuals with mental illnesses. We know we can do better. There are innovative strategies and programs that have begun to show promise in reversing this trend, stimulated in part by federal grants and initiatives, though they are being employed in a relatively small number of cities and counties across the country.

As you know, the seeds for a more significant federal role in promoting promising approaches have already been planted: In 2004, both the Senate and the U.S. House of Representatives unanimously passed the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA)

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to provide much-needed support to the field. The Act was authorized at $50 million (though $5 million per year was appropriated for fiscal years 2006 and 2007). The authorized amount would enable state and local officials to support meaningful collaborative initiatives and valuable programs, which are overseen by the U.S. Justice Department, Bureau of Justice Assistance.

As the attached overview indicates, the CSG Justice Center has long been committed to bringing the mental health, criminal justice, public health and other disciplines together with victims and consumers to address the disproportionate number of people with mental illnesses in the criminal justice system. There are many national association representatives and practitioners who have joined with us as part of our ongoing Criminal Justice/Mental Health Consensus Project to find strategies that are practical and effective at the community level. You will be hearing from some of these practitioners today and we are confident their testimony will underscore the need for federal leadership and additional resources.

Sincerely,

Rep. Michael Festa
Massachusetts House of Representatives
CSG Justice Center Board Chair

Presiding Judge
Court of Criminal Appeals, TX
CSG Justice Center Board Vice-Chair

Mr. SCOTT. Members may have additional written questions for our witnesses, and we will forward them to you and ask you, if there are any, to answer them as quickly as possible so they can be made part of the record.

And, without objection, the hearing record will remain open for 1 week for submission of additional materials.

Without objection, the hearing now stands adjourned. Thank you.

We will now be going into a Subcommittee markup on the Second Chance Act, and it will take us a few minutes to get reconfigured.

[Whereupon, at 3:12 p.m., the Subcommittee was adjourned.]